U. S. DEPARTMENT OF THE INTERIOR

AUTHORIZATION FOR DISCLOSURE OF INFORMATION FORM

The following information is provided in order to comply with the requirements of the Privacy Act of 1974, and is consistent with the provisions of 5 CFR 293, 5 USC 2951(2) and 3301, Executive Orders 12107 and 12564, and the Departmental Manual 370 DM 293. The release of information about a patient who is treated or referred for treatment of alcohol or drug abuse, or the medical results of such abuse, is governed by the Confidentiality of Alcohol and Drug Abuse Patient Record Regulations, 42 CFR, Part 2. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor and fined not more than $5,000 (5 USC 552a(I)(3) and in the case of alcohol and drug abuse patient records a falsified authorization of disclosure is prohibited under 42 CFR 2.31(d) and is punishable by a fine of not more than $500 for a first offense or a fine of not more than $5,000 for a subsequent offense in accordance with 42 CFR 2.14.

TO: ►_____
(Name of Health Services Provider -- Custodian of the Records to be Released)

►_____
(Address)

_____

You are hereby authorized to furnish information from the record of:

►_____
(Name of Subject Individual)

An employee (or prior employee) of: ►_____
(Bureau/Office/Agency)

The records are to be released to the following recipient:

Pat Needham, RN, COHN-S (on behalf of Kevin Jensen, DDS, MS, NIFC Med. Stnd. Prog. Mgr.)
(Name of Individual or Entity to Receive the Information)

DFOH Health Center, 1301 Young Street, Suite 150
(Address)

Dallas, Texas 75202

The inclusive dates for the information that is to be released, and the **specific information to be released**, are:

From October 1, 2001 To September 30, 2002

ALL medical history, examination, laboratory, procedure, and clearance or consultative records associated with this year's wildland firefighter medical examination for this firefighter.

The release is for the following specific purpose:

☐ COMPENSATION CLAIM(S)
☐ INSURANCE CLAIM(S)
☐ PRIVATE PHYSICIAN
☐ ATTORNEY
☐ SELF
☒ OTHER ***Wildland firefighter medical clearance***

If this authorization has not otherwise been revoked or has not expired in accordance with the terms of the duration statement provided above or has not been given for a longer period as set forth in the duration statement, it will terminate one year from the date of the signature.

Signature: ►	Date: ►
Signature of Parent or Guardian, if Subject is a Minor:	If the signer is other than the subject individual, indicate the relationship or authority for this request: